VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

July 11, 2016

Ms. Lois Langlois, Administrator
Rivers Edge Community Care Home
5 Hunt Street
Bennington, VT 05201

Dear Ms. Langlois:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 13, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0085	A. BUILDING: _____ B. WING _____	C 06/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERS EDGE COMMUNITY CARE HOME	5 HUNT STREET BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 6/13/16 at the Residential Care Home (RCH). The following regulatory violations were identified:	R100		
R171 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by RCH nurse, staff failed to consistently document when a medication was administered for 1 of 18	R171	REVIEWED MEDICATION DELEGATION GUIDELINES WITH DELEGATED STAFF. MEDICATIONS MUST BE PREPARED, GIVEN & DOCUMENTED FOR ONE RESIDENT AT A TIME. MEDICATIONS MUST BE DOCUMENTED AT THE TIME THEY ARE GIVEN. MM 7/5/16	

R171-R213 POCs accepted 7/11/16 FMcIntoshRN/PMC

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R171	Continued From page 1 applicable residents. (Resident #1) Findings include: Per review of the Medication Administration Record (MAR) the physician order for Resident #1 included Pro Air HFA (Albuterol sulfate inhaler) 2 puffs BID (twice daily). However, staff failed to document Resident #1 was provided the inhaler on 6/8, 9, 10 & 12. The omission of signature/initials of delegated staff was acknowledged by the RCH nurse on 6/13/16 at 2:00 PM, who had stated upon his/her review of MAR earlier in the day had also identified staff had failed to document the administration of the inhaler.	R171		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview, it was confirmed the privacy for 1 of 18 residents was breached when a photo was taken of a resident by a staff member using their personal phone and who subsequently sent the photo electronically to the RCH nurse. (Resident #2) Findings include: After Resident #2 sustained a fall on 6/5/16 and began to demonstrate physical symptoms of facial abrasions, a staff member took it upon themselves to photograph the injury and send the photo via email to the RCH nurse. As a result of	R213	STAFF INSTRUCTED TO OBTAIN PERMISSION FROM RESIDENT/FAMILY PRIOR TO TAKING PICTURES. RESIDENT RIGHTS REVIEWED WITH ALL STAFF. RESIDENT AGREED TO BE PHOTOGRAPHED ON ~~6/15~~ 6/5/16. MANAGER 7/5/16	

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R213	Continued From page 2 viewing the photo, the nurse advised staff to send Resident #2 to the Emergency Department at Southwestern VT Medical Center. Per interview on 6/13/16 at 1:45 PM, the nurse acknowledged s/he had received the email with the photo, however denied s/he had requested a photo be taken of Resident #2, without resident and family authorization, being fully aware of the privacy breach and a direct waiver of Resident Rights.	R213		